

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10655 CERTIFICATE OF DEATH

11743

Reg. Dist. No. 262

1. PLACE OF DEATH a. COUNTY Somerset.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke		c. LENGTH OF STAY IN 1b Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Pocomoke		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Samuel		First Henry	Middle Ames	Last	4. DATE OF DEATH October 16	Month	Day	Year 1956
5. SEX M.	6. COLOR OR RACE C.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH April 6, 1890	9. AGE (In years lost birthday) 66 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or Foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Ames		14. MOTHER'S MAIDEN NAME Janie Travel		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-3450437		17. INFORMANT Samuel Ames Pocomoke, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Exhaustion INTERVAL BETWEEN ONSET AND DEATH Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vomiting & Dehydration 9 days (c) Ca. of Head & Pancreas 2 wks. 9 mth.		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hypoalbuminemia due to anorexia		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED p. m. at work <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from 10/31 , 1956, to 10/16 , 1956, that I last saw the deceased alive on 10/16/56 , 19, and that death occurred at 8:55 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Cecil A. Duverney M.D. 801 Fourth St., Pocomoke City, Md 10/18/56		ADDRESS (Street, city or town, state) 801 Fourth St., Pocomoke City, Md 10/18/56					DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-21-56		22c. NAME OF CEMETERY OR CEMETARY Red Hill		22d. LOCATION (City, town, or county) Painter, VA (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Edgar Wharton - Newchurch, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE 10/22/56		24b. REGISTRAR'S SIGNATURE Mrs. Ovile Boyman		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

DEC 4 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10655

261

10656

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY							
Somerset Marion Station, Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)							
Marion, Md.		X							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS							
Philadelphia, General		Philadelphia, Pa.							
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle						
John		Last							
4. DATE OF DEATH		Month	Day						
Oct		14	1956						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH					
Male		Negro	Apr 23, 1887		9. AGE (In years last birthday) 69 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)					
farmer				Virginia					
13. FATHER'S NAME		14. MOTHER'S MOTHER'S NAME		12. CITIZEN OF WHAT COUNTRY?					
Frank Borden		Sophia Young		Somerset					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT					
no		706-30-6251		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)									
156.1 DUE TO Cancer of the liver									
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)									
DUE TO									
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield - Md.	(County)	(State)
21. I certify that I attended the deceased from Oct 15, 1956, to Oct 14, 1956, that I last saw the deceased alive on Oct 14, 1956, and that death occurred at 12 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		DATE SIGNED Oct 15, 1956	
ACTUAL SIGNATURE		Samuel A. Ross		M.D.		Crisfield - Md.			
PHYSICIAN'S NAME (Type)		Samuel A. Ross				Crisfield - Md.			
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)	
Family Cem.		10-16-56		Family Cem.		Marion - Md.			
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE			
George W. Gilgman		ADDRESS		DATE 10-15-56		Nellie W. Payne			

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25. MARIA YANNA, 1955.
26. VASSILIS, 1955.

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BUREAU V.

OCT 18 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10657

Item 11 Film 206 11-5-56

CERTIFICATE OF DEATH

10656

Reg. Dist. No.

261

1. PLACE OF DEATH a. COUNTY SOMEREST MARIAN STATION MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY SOMEREST	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARIAN STATION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED WILLIAM First		Middle Ira	Last COTTINGHAM
4. DATE OF DEATH Month Oct		Day 27	Year 1956
5. SEX MALE	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH
		WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) Marion Sta., Maryland	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME TITHUT COTTINGHAM		14. MOTHER'S MAIDEN NAME NANCY COTTINGHAM	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 222-26-2967	
17. INFORMANT Esther Bruekley - Marion - Ind		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis - C. Dut. Nephritis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
DUE TO 442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) General Arterio sclerosis		" (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Marion Sta., Ind (County) Marion Co., Ind (State) Ind	
21. I certify that I attended the deceased from at home , 19 56 , to Oct. 27, 1956 , that I last saw the deceased alive on Oct 25, 1956 , and that death occurred at Marion Sta., Ind , from the causes and on the date stated above.			
ACTUAL SIGNATURE George C. Coulbourn		ADDRESS (Street, city or town, state) Marion Station, Maryland	
PHYSICIAN'S NAME (Type) George C. Coulbourn, M.D.		DATE SIGNED 10-30-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-30-56	
22c. NAME OF CEMETERY OR CREMATORIUM Liberty Cemetery		22d. LOCATION (City, town, or county) Marion, Marion Co., Ind. (State) Ind	
23. FUNERAL DIRECTOR'S SIGNATURE George W. Tilghman Marion Sta. Ind.		ADDRESS	
24a. REC'D BY REGISTRAR Nellie D. Payne -		24b. REGISTRAR'S SIGNATURE	
DATE 10/30/56			

CERTIFICATE OF DEATH

TOMASO GIOVANNI

TOMASO GIOVANNI

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10657

10658

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b Lifetime					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.F.D. #1		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield					
3. NAME OF DECEASED (Type or print) SHIRMAN		d. STREET ADDRESS R.F.D. #1					
4. DATE OF DEATH October	Month 5	Day 19	Year 56				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1891				
9. AGE (In years lost birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0				
13. FATHER'S NAME Edward T. Justice	14. MOTHER'S MAIDEN NAME Margaret Parks	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 212-12-3362	17. INFORMANT Edgar Justice--Rt. # 1--Crisfield, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			Pulmonary Embolism			INTERVAL BETWEEN ONSET AND DEATH few hours	
Arteriosclerotic Heart Disease						3 years	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) myocardial infarction, three episodes							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Crisfield, Md.	(County)	(State)
21. I certify that I attended the deceased from Feb. 27, 1953, to Oct. 5, 1956, that I last saw the deceased alive on Oct 4, 1956, and that death occurred at 1:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crisfield, Md.							
ACTUAL SIGNATURE Dr. A. N. Parr	DATE SIGNED 10/8/56						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Sunnyridge Cemetery	22d. LOCATION (City, town, or county) Crisfield, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE 10/8/56	24b. REGISTRAR'S SIGNATURE Barbara S. Adcock				

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10659 CERTIFICATE OF DEATH

10658

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY <i>Somerset</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Somerset</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Saint Anne</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Princess Anne</i>	
d. STREET ADDRESS <i>Princess Anne</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Charles</i>	Middle <i>Franklin</i>	Last <i>Long</i>
4. DATE OF DEATH	Month <i>Oct</i>	Day <i>10</i>	Year <i>1956</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 15 1905</i>
9. AGE (In years last birthday) <i>58 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Former</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Lumber mill</i>	
10c. BIRTHPLACE (State or foreign country) <i>Md</i>		11. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Frank Long</i>		14. MOTHER'S MAIDEN NAME <i>Virginia Long</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Plural Effusion (massive)</i> 2 weeks			
DUE TO (c) <i>Bronchogenic Carcinoma</i> 3 mo.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>none</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>none</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>none</i> p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>none</i>		20f. (City or town) (County) (State) <i>none</i>	
21. I certify that I attended the deceased from <i>July 10, 1956</i> to <i>Oct 10, 1956</i> that I last saw the deceased alive on <i>Oct 10, 1956</i> , and that death occurred at <i>11:45 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>B. Frank Gigan</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>B. FRANK GIGANTI</i> DATE SIGNED <i>Princess Anne Md.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial Oct 13 1956</i>		22b. DATE THEREOF <i>Oct 13 1956</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Episcopal Cemetery</i>		22d. LOCATION (City, town, or county) <i>Princess Anne Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James Deacon Princess Anne</i>		24a. RECED BY REGISTRAR DATE <i>Oct 13 1956</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>B. H. Johnson, M.D.</i>	

18573 CERTIFICATE OF DEATH

MURKIN

BUREAU V.

OCT 17 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10669

CERTIFICATE OF DEATH

Reg. Dist. No 360

10659

1. PLACE OF DEATH a. COUNTY SOMERSET		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANOKIN		c. LENGTH OF STAY IN 1b 69 YEARS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY SOMERSET							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MANOKIN MARYLAND		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) FRANCIE		First FRANCES	Middle MADDOX	Last	4. DATE OF DEATH 10/21/56	Month 10	Day 21	Year 1956							
5. SEX FEMALE	6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/24/1887		9. AGE (In years last birthday) 69 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. HOURS 0	13. MIN. 0						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WIFE		11. BIRTHPLACE (State or foreign country) SOMERSET COUNTY MARYLAND. USA		12. CITIZEN OF WHAT COUNTRY?									
13. FATHER'S NAME BABLE DASHFIELD		14. MOTHER'S MAIDEN NAME EMMA HARMOND		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT		Address LAURENDA SCOTT MANOKIN MD	
18. CAUSE OF DEATH [Enter only one cause possible for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X		DUE TO Bronchitis - Pneumonia		INTERVAL BETWEEN ONSET AND DEATH 5 weeks		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Hour a. m. p. m. 19		Month Sept	Day 16	Year 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) MANOKIN	20f. (City or town) MANOKIN	(County) MANOKIN	(State) MARYLAND						
21. I certify that I attended the deceased from alive on Sept 16 1956 to Oct 20 1956		that I last saw the deceased and that death occurred at 8 AM from the causes and on the date stated above.													
ACTUAL SIGNATURE Eidon G. Martzman		ADDRESS (Street, city or town, state) Princess Anne, MD								DATE SIGNED 10/28/56					
PHYSICIAN'S NAME (Type) Eidon G. Martzman		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL								22b. DATE THEREOF 10/28/56	22c. NAME OF CEMETERY OR CREMATORIUM John Wesley	22d. LOCATION (City, town, or county) MANOKIN	(State) MARYLAND		
23. FUNERAL DIRECTOR'S SIGNATURE William H. Dawson Princess Anne, MD		24a. REC'D BY REGISTRAR DATE 10/28/56								24b. REGISTRAR'S SIGNATURE R. S. Johnson, M.D.					

BY ERIC SAGALYN—PHOTOGRAPH BY ERIC SAGALYN

BUREAU V. 3

28-14-2005-3 OCT 29 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10661

CERTIFICATE OF DEATH

Reg. Dist. No. 260

10660

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole		c. LENGTH OF STAY IN 1b 89 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Kate	Middle C.	Last Nutter	4. DATE OF DEATH Oct.	Month 17	Day 186	Year
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5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1873	9. AGE (in years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
		WIDOWED <input checked="" type="checkbox"/>	Divorced <input type="checkbox"/>	June 12, 1873				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME William Mc Dorman	14. MOTHER'S MAIDEN NAME Leah Heath
--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. Percy Nutter Oriole, Maryland	Address
no	no		

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Bronchial pneumonia		1 week
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Uremia		6 weeks
(c) Arteriolosclerosis of kidneys		years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Generalized arteriolosclerosis		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
--	---	--	---

21. I certify that I attended the deceased from 10-16-56, 19, to 10-17-56, 19, that I last saw the deceased alive on 10-17-56, 19, and that death occurred at 3p M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
---	---------------------------------------	-------------

ACTUAL SIGNATURE Everett C. Sutter	M.D. Dames Quarter Maryland 10-20-56	
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PHYSICIAN'S NAME (Type) Everett C. Sutter MD	22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-20-1956	22c. NAME OF CEMETERY OR CREMATORIUM Oriole Cemetery	22d. LOCATION (City, town, or county) Oriole, Maryland	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE Lewin R. Wilson	ADDRESS Princess Anne, Md.	24a. REC'D BY REGISTRAR 10-19-56	24b. REGISTRAR'S SIGNATURE R. J. Johnson, M. D.
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PRACTICAL EPISTEMOLOGY

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ANSWER TO A QUESTION

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BUREAU V. 5

OCT 24 1956

REGISTRY

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 10662

10662

CERTIFICATE OF DEATH

Reg. Dist. No. 360

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		md		b. COUNTY		Somerset							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Princess Anne		d. STREET ADDRESS		214 Beekford Ave							
Princess Anne		Life		Princess Anne		214 Beekford Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		224 Beekford		d. STREET ADDRESS		214 Beekford Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
224 Beekford				d. STREET ADDRESS		214 Beekford Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min.
Hattie					Oct	31		1956	Female	white	WIDOWED <input checked="" type="checkbox"/>	Sept 23 1870	86 yrs.				
10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
Housewife				Md		Md											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME															
Charles J. Marshall		Priscilla Porter															
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO.		17. INFORMANT													
(If yes, give war or dates of service)		no.		Priscilla Marshall		Porter											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH															
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebro-vascular accident		10 days +													
443X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO		arteriosclerotic hypertension cardio		2 years?											
(b)		vascular disease															
(c)																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Prabable carcinomatous bowel?															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from 11-35-3, 1958, to 10-10-30, 1956, that I last saw the deceased alive on Oct. 30 1956, and that death occurred at 7:50 P.M., from the causes and on the date stated above.																	
ACTUAL SIGNATURE George M. Dunn, M.D.																	
PHYSICIAN'S NAME (Type)		Princess Anne, Md.															
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)											
Burial		11/2/56		Presbyterian		Princess Anne Md											
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE											
James Lenmon		Princess Anne Md		DATE 11/2/56		R. H. Johnson, M.D.											

CERTIFICATE OF DEATH

BUREAU V. S

MAY 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10663 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10661

Reg. Dist. No. 860

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>SOMERSET</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE</u>		c. LENGTH OF STAY IN 1b <u>Westover</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ALFRED</u>		First <u>ALFRED</u>	Middle <u></u>
4. DATE OF DEATH <u>OCT 17 1956</u>		Last <u>SMITH</u>	Month <u>OCT</u>
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> JAN 15 1937 19
9. AGE (In years last birthday) yrs. <u>19</u>		10. IF UNDER 1 YEAR Months <u></u>	11. IF UNDER 24 HRS. Days <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>WESTOVER, SOM. CO.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>SAMUEL, Horsey</u>		14. MOTHER'S MAIDEN NAME <u>LOUISE SMITH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>814-34-6098</u>	
17. INFORMANT <u>LOUISE STOKENSON. PRINCESS ANNE</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured SKULL</u> DUE TO <u>825X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Second and third degree Burns</u> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Automobile Accident</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Automobile Accident</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>	
20c. TIME OF INJURY Month, Day, Year <u>7:20 p.m. 10-17 56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <u>Highway 13</u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway 13</u>		20f. (City or town) <u>Princ. Anne Somerset Md</u> (County) <u></u> (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>R. H. Johnson</u>		DATE SIGNED <u>October 19-1956</u>	
EXAMINER'S NAME (Type) <u>R. H. Johnson</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>OCT 21-56</u>	
22c. NAME OF CEMETERY OR CREMATORIAL <u>Greenwood</u>		22d. LOCATION (City, town, or county) <u>Princess Anne, Som., Ca. Md</u> (State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles H. and Marion Md.</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 19-56</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Robertson Md.</u>	

DEPARTMENT OF STATE - BALTIMORE - 18
MEDICAL EXAMINER - CERTIFICATE OF DEATH

BUREAU V.

OCT 24 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10663

Item 18 Film 9206 11-15-56 a.m. 10664 CERTIFICATE OF DEATH Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY Somerset MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crisfield		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION McCready Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First NORRIS	Middle JAMES	Last TULL 4. DATE OF DEATH Month October Day 23 Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH June 22, 1910	9. AGE (In years lost birthday) yrs. 46
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Poultry Grower		10b. KIND OF BUSINESS OR INDUSTRY For Himself	11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland
13. FATHER'S NAME Edward Tull		14. MOTHER'S MAIDEN NAME Octavia Ritchie	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-05-7016	17. INFORMANT Mrs. Elizabeth S. Tull-Crisfield, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Failure</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>	
411X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arterio Sclerosis</i> (c) <i>Thrombotic Fever - not active.</i>		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct. 1, 1956</i> , to <i>Oct. 23, 1956</i> , that I last saw the deceased alive on <i>Oct. 22, 1956</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>33 W. main St. Crisfield, Md.</i> DATE SIGNED <i>Oct. 25, 1956</i>	
ACTUAL SIGNATURE <i>Sarah M. Peyton</i>		PHYSICIAN'S NAME (Type) Dr. Sarah M. Peyton Crisfield, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 26, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Private Family Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Bradshaw & Sons—Crisfield, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>10/31/56</i>
			24b. REGISTRAR'S SIGNATURE <i>Bartee S. Gedson</i>

81. BROWNTAIL MOTH CONTROL AND STATE QUOTATIONS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10665 10664

10665

CERTIFICATE OF DEATH

Reg. Dist. No. 265

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Somerset Maryland		Md Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Cresfield	Life	Cresfield Md	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
McCready Hospital	R.S.H.		
3. NAME OF DECEASED (Type or print)	First	Middle	4. DATE OF DEATH
Theresa		e	Oct 20 1956
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Female	white		Dec 24, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Bookkeeper		Md	U.S.
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Leander James Ward	Elisabeth Francis Sterlene		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
		Madame Webster	Baltimore
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X <u>Pneumonia</u> DUE TO <u>Infection</u> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the under- (b) <u>Hypertension</u> and (c) <u>Cardiac Disease</u> ONSET AND DEATH lying cause last. DUE TO <u>Arthritis</u> 7 days			
2. DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m.	19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 15</u> , 1956, to <u>Oct 20</u> , 1956, that I last saw the deceased alive on <u>Oct 20</u> , 1956, and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE	ADDRESS (Street, city or town, state) M.D. 33 W. Main - Cresfield Md on 22		
PHYSICIAN'S NAME (Type)	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
Burial	10/23/56	Ashbury Cemetery	Cresfield Md
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
James Neuman	Cresfield Md	10/25/56	James Neuman

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BUREAU V. S.

OCT 29 1956

RECEIVE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10666

CERTIFICATE OF DEATH

10666

Reg. Dist. No. 265

1. PLACE OF DEATH a. COUNTY <i>Somerset</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>	b. COUNTY <i>Somerset</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crisfield</i>	c. LENGTH OF STAY IN 1b RURAL and give nearest town	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Crisfield</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>McCready Hospital</i>	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Rosie</i>	First Middle <i>Ward</i>	4. DATE OF DEATH <i>Oct. 18 1956</i>	Month Day Year			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Mar. 14, 1897</i>	9. AGE (In years lost birthday) <i>59 yrs.</i>	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>Richmond, Va.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Beale</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>		
16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT <i>Winter Hall-Crisfield, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> <i>Cerebral hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>6-8 hrs.</i>		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>—</i>		(b) <i>Arteriosclerosis - with previous</i> <i>2 wks.</i>		DUE TO (c) <i>episode of hemiplegia.</i>		
DUE TO						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Paralysis agitans</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 1957, to _____, 1956, that I last saw the deceased alive on <i>Oct 18 1956</i> , and that death occurred at _____, M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>Crisfield, Md.</i> DATE SIGNED <i>10/30/56</i>		
ACTUAL SIGNATURE <i>C.G. Rawley</i>		M.D.				
PHYSICIAN'S NAME (Type) <i>C.G. Rawley, M.D.</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct 22, 1956</i>		22b. DATE THEREOF <i>Oct 22, 1956</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Asbury</i>		22d. LOCATION (City, town, or county) (State) <i>Crisfield-Som. Co. Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles H. Ward - Marion St., Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>10/30/56</i>		24b. REGISTRAR'S SIGNATURE <i>Barbara J. Adams</i>

CERTIFICATE OF DEATH

8880

BUREAU V. S.

OCT 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10667

CERTIFICATE OF DEATH

10667

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Somerset		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chance, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Chance Maryland		d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Philip	Middle 	Last Wright	4. DATE OF DEATH	Month October	Day 14	Year 19 56
5. SEX male	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH September 8, 1956	9. AGE (In years lost birthday) yrs. 1	IF UNDER 1 YEAR Months 1	IF UNDER 24 HRS. Days 7	Hours Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Thomas Gerald				14. MOTHER'S MAIDEN NAME Ruth Wright			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mother		Address Chance Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration				INTERVAL BETWEEN ONSET AND DEATH 3 days			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 571.0 (b) DUE TO Gastroenteritis				3 days			
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-14-56 , 19____, to 10-14-56 , 19____, that I last saw the deceased alive on 10-14-56 , 19____, and that death occurred at 7:30PM , from the causes and on the date stated above. ACTUAL SIGNATURE Everett C. Sutter		ADDRESS (Street, city or town, state) Dames Quarter, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-15-56		22c. NAME OF CEMETERY OR CREMATORIAL Private Burial grounds		22d. LOCATION (City, town, or county) Chance Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE No undertaken		ADDRESS 2082191X14		24a. REC'D BY REGISTRAR DATE 10/15/56		24b. REGISTRAR'S SIGNATURE Lola J. Healthy	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Late because cert. went to Welfare Dept.
10/19/56 M.B.

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BUREAU A.

OCT 19 1956

REGEIV ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10668

Item 7 FilmG205 10-10-56 et

10668

CERTIFICATE OF DEATH

Reg. Dist. No. 260

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Somerset		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Princess Anne			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Princess Anne		Princess Anne	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Edward Goldley			
4. DATE OF DEATH		Last	Month
		Oct	3rd
		Day	Year
		1955	
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
Male		Col	Never married
8. DATE OF BIRTH		9. AGE (In years lost birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.	
February 1874		84 yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Labor		Farm	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Old Bynum, Tenn.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Jerry Yokley		Jane?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Dr. Orange Yokley - Princess Anne	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
592X		Cerebral Haemorrhage	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b)		Hypertension	
DUE TO			
(c)		Chronic Interstitial Nephritis	
DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 24, 1956, to Oct 3, 1956, that I last saw the deceased alive on Oct 3rd, 1956, and that death occurred at 11:00 A.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE Eldon G. Marksman, M.D.		Princess Anne 10-3-56	
PHYSICIAN'S NAME (Type)		Eldon G. Marksman, M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		Oct. 7, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
East Bernstadt		London Kentucky	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
Dr. Edgar Thomas		Accomac, VA	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE 10/3/56		R. H. Johnson, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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BUREAU

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